PRINTED:

10/19/2011

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO LDING	NSTRUCTION 00	l'	TE SURVEY MPLETED
	155348	B. WIN			- 09/2	7/2011
NAME OF PROVIDER OR SUPPLIER PARKVIEW CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2819 NORTH ST JOSEPH AVENUE EVANSVILLE, IN47720				
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PERCEDED BY FULL C IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
This visit was for the Complaint IN0009 resulted in a Partial Survey-Substandar Complaint IN0009 Federal/State defice F221 and F323. Survey date: September Facility number: 00 Provider number: 1002 Survey team: Annumber: 1002 Survey team: Annumber: 82 Total: 82 Census payor type Medicare: 10 Medicaid: 53 Other: 19 Total: 82 Sample: 3 Supplemental samples of the Survey team: 3 Supplemental samples deficiencies	lly Extended rd Quality of Care. 7455 Substantiated, iencies are cited at ember 27, 2011 00239 155348 290150 e Marie Crays RN	F0	0000	Please accept this pla correction as my credi allegation of complian plan of correction is sunder federal and static regulations and statute applicable to long term providers. This plan of does not constitute an of liability on the part of facility, and such liabil specifically denied. The submission of this plan constitute agreement if facility that the survey or conclusions are acceptable constitute deficiency, of scope and severity regord the deficiencies cited correctly applied.	ible ce. This ubmitted e es n care f correction admission of the ity is hereby ie n does not by the ors findings curate, or that the garding any	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

FEXU11

Facility ID:

000239

TITLE

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/19/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155348			(X2) MULTIPLE CC A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 09/27/2011
	PROVIDER OR SUPPLIER		2819 N	ADDRESS, CITY, STATE, ZIP CODE ORTH ST JOSEPH AVENUE VILLE, IN47720	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	Quality review c Cathy Emswiller	ompleted 10/3/11 RN			
F0221 SS=F	physical restraints discipline or conve- treat the resident's Based on observe- record review, the side rail assessmaccurate in asses side rails; failed	the right to be free from any imposed for purposes of enience, and not required to a medical symptoms. The action, interview, and the facility failed to ensure ents were complete and using the potential use of to assess for safety issues derails; and failed to	F0221	Affected by alleged practice:Residents, A,B,C,D E now have accurate sidera assessments completed by Nursing Administration whici includes assessment for saf Any changes were commun	il h ety.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

FEXU11

Facility ID:

000239

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155348 09/27/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2819 NORTH ST JOSEPH AVENUE PARKVIEW CARE CENTER EVANSVILLE, IN47720 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE to the staff through updated communicate the use of side rails to all careplans and care guides on staff, in 2 of 2 units reviewed for side rail 9/28/11 by Nursing use and for 3 of 3 residents reviewed for Administration. Unit manager #1 side rail use in a sample of 3, and 2 of 2 and #2 as well as LPN#2 have been educated by the DON on residents reviewed in the supplemental the appropriate protocol for sample of 2. This deficient practice had siderail usage on 9/28/11 the potential to affect 82 of 82 residents including obtaining physicians with siderails attached to their beds. orders as well as updating the Residents A, B, C, D, and E. careplan and care guides to reflect accurate information. 2.)Potential to be Findings include: affected:Residents residing in the facility have the potential to be 1. On 9/27/11 at 8:25 A.M., during the affected therefore a 100% audit will be completed by Nursing initial tour of the Dogwood Unit, Unit Administration by 10/21/11 to Manager # 2 indicated that 6 out of 48 ensure siderail assessments are residents who resided on her unit were up accurate and include assessment for safety as well. Any changes ad lib, and did not use siderails. 42 of 48 will be communicated to staff by residents used side rails. The 6 residents being addressed on the careplan who did not utilize siderails continued to and care guides. 3.) Systemic have the siderails bolted to the bed, but changes:Re-education to Nursing were kept in the down position. Unit Administration was conducted by the DON on 9/28/11. This Manager # 2 indicated that all of the side education included the rails were the same and that they were completion of accurate siderail considered 1/2 rails. Unit Manager # 2 assessments and safety related indicated all of the side rails on her unit to siderails as well as appropriate place, and functioning of alarms. were not considered restraints, and that all Education has been provided to were used for bed mobility. the ICPT on 9/30/11 by the Executive Director to include the On 9/27/11 at 8:40 A.M., during the accuracy of careplans and care guides to reflect appropriate side initial tour of the Holly Unit, LPN # 2 rail interventions and safety alarm indicated that 2 of 34 residents who interventions. Education also resided on her unit did not use siderails. included that a new siderail 32 of 34 residents used side rails. LPN # 2 assessments are to be completed on admissions and readmissions. indicated all of the rails were 1/2 rails and

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If continuation sheet

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l i		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155348	B. WIN			09/27/2	U11
NAME OF	PROVIDER OR SUPPLIEF	8		1	ADDRESS, CITY, STATE, ZIP CODE		
	TALOADE OFNITED			1	ORTH ST JOSEPH AVENUE		
PARKVII	EW CARE CENTER			EVANS	VILLE, IN47720		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION
TAG	+	LSC IDENTIFYING INFORMATION)		TAG	with quarterly, annual and		DATE
		d mobility. The 2			significant change MDS. Sid	lerail	
		d not use siderails were			assessments will be complet		
		e siderails mounted to the			by Nursing Administration an		
		own position. LPN # 2			indicated as a restraint thera	ру	
		esidents utilized only a			will be involved as well.4.) Method to monitor:Siderail		
		one side of the bed; for			assessments, careplans, and	t	
	_	ther side of the bed was			care guides will be audited for	or	
	against the wall.				accuracy ongoing through th		
					care planning process weekl scheduled by the ICPT, as w		
		00 A.M., LPN # 2			with any new physician's ord		
	1 *	rent CNA assignment			at least Monday-Friday. Aud		
		the units. 17 of the 82			results will be reported to the		
		ention of siderails being			Committee monthly for 12		
	utilized.				months. PI Committee will determine need for further au	ıdite	
					with threshold at 95%. Plan		
	On 9/27/11 at 9:4	45 A.M., during interview			be updated as indicated. 5.)		
	with the Director	r of Nursing [DON], she			Completion date October 21,		
	indicated side ra	ils should be removed			2011.		
	from the bed if the	hey are not being used.					
	She indicated a f	facility audit was					
	completed on 9/2	23/11, in which all					
	resident beds we	ere assessed for the					
	distance between	n the side rails and					
	mattress; and that	at side rail assessments					
	and care plans w	ere reviewed for					
	appropriateness	for use.					
	On 9/27/11 at 11	:25 A.M., during					
	interview with U	Init Manager # 1, she					
		nts who use side rails					
	should have a ph	ysician's order.					
	1	-					
	On 9/27/11 at 3::	30 P.M., during interview					
		ger # 2, she indicated the					

000239

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155348		(X2) MULTIPLE A. BUILDING B. WING	CONSTRUCTION 00		e survey pleted /2011	
	PROVIDER OR SUPPLIER		STREE 2819	ET ADDRESS, CITY, STATE, ZIP CODE NORTH ST JOSEPH AVENU NSVILLE, IN47720		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPF DEFICIENCY)	LD BE	(X5) COMPLETION DATE
	CNA assignment	hould be printed on the sheets, and the nurse n the TAR [treatment cord].				
	A was reviewed of Diagnoses include	nical record of Resident on 9/27/11 at 9:05 A.M. led, but were not limited Cerebral Vascular				
	Service form, dat "Cognitive Stat Memory LossE Assistance to Re 1-2 Person Assis	Collection Tool/Nursing ted 3/8/11, indicated, tus, Alert, Short Term Bed Mobility, Requires position SelfTransfers, tanceToileting Needs unipulate Clothing and"				
	indicated: "Why being considered For Safety, Other railsSecurity, F Will the side raild Turning side to s down in bed, Yes consciousness No status Yes diagnorail(s) is/are recodue to: Resident Type, 1/2 partial	ssment, dated 3/8/11, is the use of a side rail(s) ? Resident requested - rCognitive, Requested fear of rolling out of bed. (s) assist the resident in: ide Yes, Moving up and sFluctuations in to, Decline in cognitive tosis of dementiaSide mmended at this time request. Recommended rail Left upper, Right mended Use, Side rail(s) are				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155348		(X2) MULTI A. BUILDIN B. WING		00	(X3) DATE S COMPL 09/27/2	ETED	
	PROVIDER OR SUPPLIER		28	319 NC	DDRESS, CITY, STATE, ZIP CODE DRTH ST JOSEPH AVENUE VILLE, IN47720		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	II PRE TA	FIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	is in bedReside on/in [left blank] significant chang order has been of unchecked]. Plan unchecked]."	n of care updated [left					
	A "Nursing Assessment of Fall," dated 3/27/11 at 4:15 A.M., indicated, "Trying to go to B/R [bathroom] rolled lower extremities our of bed (low bed) onto the floor had chest et [and] head on bed - holding on to siderails"						
	Nurse's Notes in notations:	cluded the following					
	5/13/11 at 11:40 P.M.: "Resident noted by CNA to be laying on stomach in the floor of his room holding on to bed rail [with] Right arm [and] Neck resting on bed rail. Slight redness noted to [left] knee [and] front of neck"						
	5/13/11, indicate upResident not the side rail [with resting on side raws on the floor. changes/instructions of the side rail [with resting on side raws on the floor.	ssment of Fall," dated d: "In bed. Tried to get ted on stomach holding h] [right] hand and neck hil, the rest of his bodyCare Plan fons[Left blank]"					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPL	E CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00		COMPLETED	
		155348	B. WING			09/27/2011	
NAME OF I	PROVIDER OR SUPPLIER	<u> </u>		EET ADDRESS, CITY, S			
DA DI () (15	TALOADE OFNITED		I	9 NORTH ST JOS			
PARKVIE	EW CARE CENTER		EVA	NSVILLE, IN4772	20		
(X4) ID		STATEMENT OF DEFICIENCIES	ID		R'S PLAN OF CORRECTION	(X5)	
PREFIX TAG	1	ICY MUST BE PERCEDED BY FULL	PREFIX	CROSS-REFERE	CTIVE ACTION SHOULD BE NCED TO THE APPROPRIAT DEFICIENCY)		1
IAG		LSC IDENTIFYING INFORMATION)	TAG		DEFICIENCE)	DATE	
	l lall was lacking	in the clinical record.					
	A Minima on Dat	C.4 [MDC]					
		a Set [MDS] assessment,					
	· ·	dicated the resident					
		of 15 for cognitive status,					
		ig no mental impairment,					
		ensive assistance of two+					
	starr for bed mot	pility and transfer.					
	TI C:1 D :1 A	.1. 1					
		ssessment had an					
	addendum, dated						
	indicated, "1/2 S	R [side rails] in use."					
	Nurgala Natas de	ated 9/23/11 at 4:10					
	· ·						
	· ·	"Called to resident room					
	1 -	nt on floor with left arm					
	1 ^	ned between side rail and					
	i -	esting on rail. Resident					
	_	no pulse or heart rate s nurse arrived in resident					
		n low position, tabs alarm					
		not sounding, 1/2 side nobility and positioning.					
		, ,					
	EMS unable to re	evive resident.					
	An additional Ca	are Plan, initially dated					
		red with a goal date of					
	1 *	ted with a goar date of					
	help completing	•					
		ided: "Provide one half					
	mobility."	t me with my bed					
	inounity.						
	Physician orders	for the side rails were					
	i nysician orders	TOT THE SIDE TAILS WELL					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			(X2) MI	JLTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155348	B. WIN			09/27/2	011
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	l	
NAME OF 1	PROVIDER OR SUPPLIER				ORTH ST JOSEPH AVENUE		
PARKVI	EW CARE CENTER				VILLE, IN47720		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	lacking in the cli	nical record.					
	Documentation v	was lacking on the					
		nistration Record that the					
	resident had half	side rails in place.					
	During interview	with the Director of					
	Nursing [DON]	on 9/27/11 at 9:45 A.M.,					
	she indicated R	esident A utilized his side					
	rails to assist hin	n in turning side to side.					
		C					
	During interview	with LPN # 1 on					
	9/27/11 at 10:45	A.M., she indicated she					
	was the nurse wo	orking on 9/23/11. LPN #					
		l past Resident A's bed at					
		50 A.M., and he was					
		bly. LPN # 1 indicated					
		rted her "bed check" at					
		:10 A.M., and found					
		with his knees on the					
	1	t arm and face between					
	· '	the mattress. LPN # 1					
		and face were not					
	_	at the chin was more					
	"	r inner part of the side					
	rail.						
	Domin v int						
	_	with CNA # 1 on					
		A.M., she indicated she					
		o found Resident A. She					
		t saw the resident at					
		25 A.M., and she					
	repositioned him	on his right side. CNA#					
	1 indicated when	she went in the					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BIII	LDING	00	COMPL	ETED
		155348	B. WIN			09/27/2	011
		l .	D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	8		1	ORTH ST JOSEPH AVENUE		
PARKVIE	EW CARE CENTER			1	VILLE, IN47720		
(X4) ID	SUMMARYS	STATEMENT OF DEFICIENCIES		ID			(X5)
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TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	DATE
		at approximately 4:10					
		the resident with most of					
	· ·						
	1 -	floor, and his left arm on					
	_	he rail. She indicated the					
		as resting against the bed					
	rail.						
	D. singer in the contract of t	MILITERIA NA CONTRA DE LA CONTRA DEL CONTRA DE LA CONTRA DEL CONTRA DE LA CONTRA DEL CONTRA DE LA CONTRA DEL CONTRA DE LA CONTRA DEL CONTRA DE LA CO					
		w with Unit Manager # 1					
		:25 A.M., she indicated					
		e rail assessment was					
	_	he should have had a					
		r for the side rails. She					
	indicated the sid	e rails would be listed on					
	the care plan as	an intervention for bed					
	mobility.						
		8:25 A.M., during the					
	initial tour, Unit	Manager # 2 indicated					
	Resident E was t	up ad lib, and did not					
	utilize his side ra	ails. Resident E was					
	observed at that	time lying in bed, with					
		on both sides of the bed.					
	_	2 indicated that the					
		rt and oriented, and if he					
		nem up, he could.					
	l martine to pun ti	op, no oona.					
	The clinical reco	ord of Resident E was					
		7/11 at 3:00 P.M.					
		ded, but were not limited					
	to, Muscle Weak						
	io, masere wear						
	A Physician's or	der, initially dated on					
	1 *	•					
		l, "Half upper side rails					
	2/2/11 and on the	der, initially dated on e current September 2011					
	orders, indicated	, mail upper side rails					

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		ì		INSTRUCTION 00	(X3) DATE S COMPL		
		155348	A. BUI B. WIN			09/27/2	011
	PROVIDER OR SUPPLIER			2819 N	ADDRESS, CITY, STATE, ZIP CODE ORTH ST JOSEPH AVENUE VILLE, IN47720		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	for increased bed	mobility."					
	dated 12/22/10 arindicated, "Why being considered For [increased] be mobilityRecommail Left upper lo Recommended U Uses 1/2 SR at nisside." The current CNA reviewed on 9/27 not indicate the urinitial tour, LPN utilized bed rails observed at that the considered indicated in the urindicate of the urinitial tour, LPN utilized bed rails.	wer Right upper lower, Use [left blank]8/29/11 Eight to aid turning side to assignment sheet, U/11 at 11:00 A.M., did use of the side rails. 8:40 A.M., during the # 2 indicated Resident B					
	reviewed on 9/27 Diagnoses includ	rd of Resident B was 7/11 at 12:05 P.M. led, but were not limited Alzheimer's Disease.					
	and on the current indicated, "Low l	der, initially dated 1/7/11 at September 2011 orders, bed placement," and s to assist with bed					

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			ULTIPLE CO	ONSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
		155348	B. WIN	G		09/27/2	011
NAME OF F	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
				1	ORTH ST JOSEPH AVENUE		
PARKVIE	EW CARE CENTER			EVANS	VILLE, IN47720		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
ı	A C: 1. D .: 1 A						
		ssment, initially dated					
	· ·	d, "Why is the use of a					
	, , -	considered? Resident					
	requested: to assi						
	1	nmendations Side rails(s)					
		d at this time due to:					
	1 ^	. Recommended Type:					
		eft upper Right upper.					
	Recommended U	Jse, Side rail(s) are					
	recommended at	all times when resident					
	is in bed" The	assessment was updated					
	on 9/30/10, 1/7/1	1, 3/26/11, 4/19/11,					
	7/11/11, and 9/16	5/11. The most recent					
	notation, dated 9	/16/11, indicated, "No					
		OC [plan of care]."					
	-	-					
	A "Nursing Asses	ssment of Fall," dated					
	6/14/11 at 6:15 P	.M., indicated, "Exact					
	Location: Bedsid	le by bed in resident's					
	roomPossible (Causative [sic] factors					
	identified: Confu						
	A Minimum Data	a Set [MDS] assessment,					
		icated the resident scored					
	· ·	cognition, with 15					
		ntal impairment, and					
	_	ve assistance of two +					
	staff for bed mob						
	Juli 101 000 11100	·					
	A Care Plan init	ially dated 7/10/10 and					
		arget date of 12/15/11,					
	_	em of "[Resident B] is at					
	risk for skin brea						
	115K TOT SKIII UTCA	AUGWII UUC IO					

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			ULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BIII	LDING	00	COMPL	ETED
		155348	B. WIN			09/27/20	011
NAME OF I	DROVIDED OF GUIDNIED		!		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER			2819 N	ORTH ST JOSEPH AVENUE		
	EW CARE CENTER				VILLE, IN47720		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
IAG			+	TAG	BLITCHENC!)		DATE
		he approaches included:					
		f siderails to assist with					
	bed mobility."						
	_	with the DON on					
		.M., she indicated that					
		low beds due to fall					
	risks, and that the	e side rails were to assist					
	the residents with	n bed mobility.					
	During review of	f the CNA assignment					
	sheet, on 9/27/11	at 11:00 A.M.,					
	documentation of	f the use of side rails was					
	lacking.						
	5. On 9/27/11 at	8:40 A.M., during the					
		# 2 indicated Resident C					
	· ·	s. Resident C was					
		time lying in a low bed					
		ls up on both sides of the					
	bed.	is up on both sides of the					
	ocu.						
	The clinical reco	rd of Resident C was					
	reviewed on 9/27						
	_	led, but were not limited					
	to, Dementia.						
	A Cida Dail A	annum initially dated					
		ssment, initially dated					
	3/7/08 and last up	-					
	· ·	is the use of a side rail(s)					
	being considered? Resident requested for:						
	I -	al Symptoms Pain,					
	Cognitive: Impai	_					
	walkingSide ra	il(s) are recommended at					

STATEMEN	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X			ULTIPLE CC	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	ETED
		155348	B. WIN			09/27/2	011
				_	ADDRESS, CITY, STATE, ZIP CODE	1	
NAME OF I	PROVIDER OR SUPPLIER	<u>.</u>		2819 N	ORTH ST JOSEPH AVENUE		
	EW CARE CENTER				VILLE, IN47720		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	1	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DETICIENC!)		DATE
	this time due to:						
	1 ^	mended Type, 1/2 partial					
		Right Upper. Side rail(s)					
		d at all times when					
		" The most recent					
	· ·	/28/11, indicated, "No					
	changes, continu	e POC."					
	A Physician's ord	der, initially dated 5/13/11					
	1 -	nt September 2011 orders,					
		Side Rails for bed					
	mobility."	Side Ruiis for bed					
	moonity.						
	A Care Plan, date	ed 5/13/11, indicated a					
	problem of: "I ha	ave a history of falls." The					
	l ^	cated: "Half siderails up					
	1	ssist with bed mobility.					
	Does not prevent	•					
	Boos not provent						
	A MDS assessme	ent, dated 8/20/11,					
	indicated the resi	ident scored a 1 out of 15					
	for cognition, w	ith 15 indicating no					
	mental impairme	ent, and required					
	1 ^	nce of two+ staff for bed					
	mobility and tran						
	During review of	f the CNA assignment					
	sheets, on 9/27/1	1 at 11:00 A.M.,					
	· ·	as lacking that Resident					
	C utilized side ra						
	6. On 9/27/11 at	8:40 A.M., during the					
	initial tour, LPN	# 2 indicated Resident D					
	· ·	sired and did not utilize					
	was up as she de	sired and did not utilize					

000239

l	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155348	(X2) MULTIPLE CO A. BUILDING B. WING	00	li i	E SURVEY PLETED /2011
	PROVIDER OR SUPPLIER		2819 N	ADDRESS, CITY, STATE, ZIP CO ORTH ST JOSEPH AVE VILLE, IN47720		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
		nils were observed on oed; up on one side and er side.				
	reviewed on 9/27 Diagnoses include to, General Debi Disease. A MDS assessme indicated the resi for cognition, we mental impairmed assistance of one and transfer. A Care Plan, date a target date of 1 problem of "Nee bathing, dressing The approaches if for bed mobility. A Side Rail Asse but most recently indicated, "Why being considered Bed MobilityR partial rail Left URecommended UR	led, but were not limited lity and Alzheimer's ent, dated 7/20/11, ident scored a 3 out of 15 with 15 indicating no ent, and required limited a person for bed mobility ed 8/5/10 and updated to 0/23/11, indicated a ds assistance to complete and grooming tasks." included: "1/2 siderails " ssment, initially undated wupdated 7/23/11, is the use of a side rail(s) l? Resident requested For ecommended Type, 1/2 Upper, Right Upper, Use [left blank]7/23/11				
	Uses 1/2 SR to a mobility."	ssisi [witii] ocu				

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDI		NSTRUCTION 00	COMPL	ETED	
		155348	B. WING			09/27/2	011
	PROVIDER OR SUPPLIER		2	819 NC	DDRESS, CITY, STATE, ZIP CODE DRTH ST JOSEPH AVENUE VILLE, IN47720		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PRI	D EFIX AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	re	(X5) COMPLETION DATE
	<u>-</u>	ler, dated 9/23/11, derails up to aid in bed					
	sheets on 9/27/11	f the CNA assignment at 11:00 A.M., f the use of siderails was					
	Rails, dated 11-8 DON on 9/27/11 included: "1. A S be completed uporeadmission, and physician's order Restraint Informorequired for the undetermined to be are supplied with need for side rail as to their purpos When side rails a kept in the lowes care is being pro-	as needed. 2. A and signed Physical ed Consent form are use of side rails if they are a restraint. 3. All beds bed rails. 4. When a s arises, instruct residents se and correct use. 5. are indicated, bed must be t position, except when					
	IN00097455. 3.1-26(o)	1					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/19/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155348		IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED 09/27/2011			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 2819 NORTH ST JOSEPH AVENUE EVANSVILLE, IN47720					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE			
F0323 SS=F		nsure that the resident ins as free of accident						
ЭЭ-Г	hazards as is poss receives adequate devices to prevent Based on intervi- facility failed to assessed for safe	sible; and each resident e supervision and assistance	F0323	affected by alleged practice:Residents, A,B,C,D, now have accurate siderail assissments completed by Nursing Administration which				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

FEXU11

Facility ID:

000239

If continuation sheet

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE : COMPL		
AND PLAN	OF CORRECTION		A. BUI	LDING	00	l	
		155348	B. WIN	NG		09/27/2	011
NAME OF	PROVIDER OR SUPPLIER			1	DDRESS, CITY, STATE, ZIP CODE		
PARKVII	EW CARE CENTER			1	VILLE, IN47720		
(X4) ID	I SUMMARY S	STATEMENT OF DEFICIENCIES		ID I			(X5)
PREFIX		ICY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	1	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		DATE
	attached: failed t	to ensure interventions of			includes assessment for safe	ety	
	· '	arms were documented			and if indicated to include the	e use	
		care plan; and failed to			of functioning alarms. Any		
	1	utilized to alert staff of a			changes have been		
					communicated to the staff through updated careplans a	nd	
	_	ot to rise unassisted was			care guides to reflect accurate		
	1	perly, for 1 of 3 residents			information.Unit Managers #		
		s, in sample of 5.			and#2 and LPN#2 have beer		
	1	facility also failed to			educated by the DON on 9/2		
	ensure side rail a	assessments were			on the appropriate protocol for		
	complete and ac	curate in assessing the			siderail usage including obta		
	potential use of	side rails; failed to assess			physician orders, and update careplans and care guides to		
	1 -	with the use of siderails;			reflect accurate information.2		
	1	nmunicate the use of side			Potential to be affected:Resid	•	
		in 2 of 2 units reviewed			residing in the facility have th		
	1	and for 3 of 3 residents			potential to be affected there		
		e rail use in a sample of 3,			a 100% audit will be complet	ed by	
		ents reviewed in the			Nursing Administration by 10/21/11 to ensure all sideral	ii	
					assessments are accurate a		
		mple of 2. This deficient			include assessments for safe		
	1 ^	potential to affect 82 of			well as including appropriate	·	
		n siderails attached to			alarms if indicated. Any char	nges	
	their beds. Resid	lents A, B, C, D, and E.			will be addressed on the		
					careplan and care guides as as physician orders will be	weii	
	Findings include	»:			obtained for safety devices.3	.)	
					Systemic changes:Re-educa		
	1. On 9/27/11 at	8:25 A.M., during the			to Nursing Administration wa	s	
	initial tour of the	e Dogwood Unit, Unit			conducted by the DON on		
	Manager # 2 ind	icated that 6 out of 48			9/28/11. The re-education		
	1	sided on her unit were up			included the completion of accurate siderail assessmen	ts	
		ot use siderails. 42 of 48			and safety related to siderails		
	1	de rails. The 6 residents			well as appropriate placemer		
		ze siderails continued to			and function of alarms.		
	have the siderails bolted to the bed, but were kept in the down position. Unit			Re-education with the ICPT v	was		
				conducted by the Executive Director on 9/30/11 to include	e the		
	1 -	icated that all of the side			accuracy of careplans and ca		
	I managet # 2 mg	icated that all of the side					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	ETED
		155348	B. WIN			09/27/2	011
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIEI	₹		1			
DA DIA W	TALOADE OFNITES			1	ORTH ST JOSEPH AVENUE		
PARKVII	EW CARE CENTER	(EVANS	VILLE, IN47720		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	_	DATE
	rails were the sa	me and that they were			guides to reflect appropriate		
	considered 1/2 ra	ails. Unit Manager # 2			siderail and safety alarm		
		he side rails on her unit			interventions. Education als	0	
		ered restraints, and that all			included that a new siderail		
		·			assessment including assessment for safety and if		
	were used for be	ed mobility.			indicated the need for alarms		
					be completed on admission		
		40 A.M., during the			readmission as well as with		
	initial tour of the	e Holly Unit, LPN # 2			quarterly, annual and signific	:ant	
	indicated that 2	of 34 residents who			change MDS. Alarms may b		
	resided on her u	nit did not use siderails.			assessed as needed at any		
	32 of 34 residen	ts used side rails. LPN # 2			time or indication. These sid		
		he rails were 1/2 rails and			and safety assessments are	to be	
					completed by Nursing Administration and if indicate	nd ac	
		ed mobility. The 2			a restraint, therapy will be	u as	
		d not use siderails were			involved as well. 4.) Method	to	
		e siderails mounted to the			Monitor:Siderail asessments		
	bed, but in the d	own position. LPN # 2			safety devices, careplans, ar		
	indicated some r	esidents utilized only a			care guides will be audited for		
	half side rail on	one side of the bed; for			accuracy ongoing through th	е	
		ther side of the bed was			careplan process weekly as		
	against the wall.				scheduled by the ICPT, as w		
	agamst the wan.				with any new physician orde least Monday-Friday. Result		
	On 0/27/11 -4 0	00 A M I DN # 2			audits will be reported to the		
		00 A.M., LPN # 2			Committee for 12 months. T		
	1 *	rent CNA assignment			PI Committee will determine		
	sheets for all of	the units. 17 of the 82			need for further audits with		
	residents had me	ention of siderails being			threshold at 95%. the plan v	vill be	
	utilized.				updated as indicated.5.)		
					Completion date October 21	,	
	On 9/27/11 at 9:	45 A.M., during interview			2011.		
		r of Nursing [DON], she					
		~					
	indicated side rails should be removed						
		hey are not being used.					
		facility audit was					
	completed on 9/2	23/11, in which all					
	resident beds we	ere assessed for the					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155348		(X2) MUL A. BUILD B. WING		00	(X3) DATE S COMPL 09/27/2	ETED	
	PROVIDER OR SUPPLIER			2819 NC	DDRESS, CITY, STATE, ZIP CODE DRTH ST JOSEPH AVENUE /ILLE, IN47720	l	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
ind	distance between	the side rails and t side rail assessments ere reviewed for		IAG			BAIL
		nit Manager # 1, she ts who use side rails					
	with Unit Manag use of siderails sl CNA assignment	80 P.M., during interview er # 2, she indicated the mould be printed on the sheets, and the nurse in the TAR [treatment cord].					
	A was reviewed of Diagnoses include	nical record of Resident on 9/27/11 at 9:05 A.M. led, but were not limited Cerebral Vascular					
	Service form, dat "Cognitive Stat Memory LossE Assistance to Re 1-2 Person Assis	collection Tool/Nursing and 3/8/11, indicated, and the Alert, Short Term and Mobility, Requires position SelfTransfers, tanceToileting Needs anipulate Clothing and"					
	l '	ated 3/8/11 at 2:00 P.M., rt to self et [and] family					

000239

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULT	TIPLE CO	NSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155348	A. BUILDI	NG	00	COMPL 09/27/2	
		133340	B. WING			03/21/2	011
NAME OF I	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE ORTH ST JOSEPH AVENUE		
PARKVIE	EW CARE CENTER		I		VILLE, IN47720		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	1	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		EFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Έ	COMPLETION DATE
1710		pecific day of the	1	1710	·		DATE
		recall name of facility.					
		ory lossQuiet only					
		oken toRes [resident]					
	transfers [with] e						
	1	vo] staff, requires lots of					
	1	Encouraged to [assist]					
	1 5 5	p in bed. Requires [assist]					
		ityRequires total					
	[assist] [with] Al	DL's [activities of daily					
	living]"						
	A Fall Risk Eval	uation, dated 3/8/11,					
	indicated: "Do	es the resident display					
	any of the follow	ring behaviors: easily					
	distracted; period	ls of altered perception or					
	awareness of sur	roundings; episodes of					
	disorganized spe	• •					
	_	ods of lethargy; mental					
		ver the course of the day;					
	•	e and resists care. Yes.					
	Vision StatusN	•					
	impairedElimii						
		ulates with problems and					
		nsteady, but able to					
		it physical support"					
		ndicated the "Total Score"					
	_	at who scores a 10 or					
	higher is at risk	¨J.					
	A Side Rail Asse	ssment, dated 3/8/11,					
		is the use of a side rail(s)					
	I -	? Resident requested -					
	For Safety, Othe	rCognitive, Requested					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155348		(X2) M A. BUII		ONSTRUCTION 00	(X3) DATE S COMPLE	ETED	
		100040	B. WIN			09/27/20	J11
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
PARKVIE	EW CARE CENTER				ORTH ST JOSEPH AVENUE VILLE, IN47720		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE
	•	ear of rolling out of bed.					
		(s) assist the resident in:					
	down in bed, Yes	ide Yes, Moving up and					
	·	o, Decline in cognitive					
		sis of dementiaSide					
	_	mmended at this time					
	` '	requestRecommended					
		are recommended at all					
	. ,	ent is in bedResident					
		d on/in [left blank] or					
		a significant change in					
		cian order has been					
	obtained[left ui	nchecked]. Plan of care					
	updated [left unc	hecked]."					
	A "Nursing Asses	ssment of Fall," dated					
	_	.M., indicated, "Trying					
		hroom] rolled lower					
	_	f bed (low bed) onto the					
		[and] head on bed -					
	holding on to sid						
	Causative factors	identified: Not ringing					
	for assist to B/R.	•					
	changes/instructi	ons[Left blank]"					
	 A Fall Risk Eval	uation, dated 4/16/11,					
		dent remained at a high					
		h a Total Score of 25.					
	, // -v -						
	Nurse's Notes inc	cluded the following					
	notations:	Č					
	5/13/11 at 11:40	P.M.: "Resident noted by					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

FEXU11 Facility ID:

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If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155348		A. BUI	LDING	NSTRUCTION 00	(X3) DATE (COMPL 09/27/2	ETED	
		133340	B. WIN		DDRESS, CITY, STATE, ZIP CODE	09/21/2	
NAME OF I	PROVIDER OR SUPPLIER				ORTH ST JOSEPH AVENUE		
	EW CARE CENTER			EVANS	VILLE, IN47720		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
1710		g on stomach in the floor		ing	·		DATE
	, ,	ing on to bed rail [with]					
		Neck resting on bed rail.					
		oted to [left] knee [and]					
	front of neck"	ned to [left] knee [unu]					
	Home of neck						
	A "Nursing Asse	ssment of Fall," dated					
		d: "In bed. Tried to get					
	· ·	ed on stomach holding					
	1 ^	n] [right] hand and neck					
	-	nil, the rest of his body					
	was on the floor.	-					
		ons[Left blank]"					
		[]					
	A new side rail a	ssessment was lacking in					
	the clinical recor	_					
		er this fall were lacking in					
	the clinical recor	•					
		uation, dated 5/21/11,					
		ident remained a high risk					
	· ·	otal score of 21. An					
		ation, dated 7/5/11,					
	indicated a total	score of 26.					
	A Minimum D	- Cat [MDC] assured					
		a Set [MDS] assessment,					
	1	dicated the resident					
		of 15 for cognitive status,					
	_	ensive assistance of two+					
	stall for bed mob	oility and transfer.					
	The Side Rail As	sessment had an					
	addendum, dated	17/15/11, which					
	· ·	R [side rails] in use."					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO.	NSTRUCTION 00	COMPI		
11.15 12.11.	or conditions	155348	1 ' '	LDING		09/27/2	
			B. WIN		DDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER			1	ORTH ST JOSEPH AVENUE		
PARKVIE	W CARE CENTER			1	VILLE, IN47720		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	NI anala Nistan d	-4-10/22/11 -4 4-10					
		ated 9/23/11 at 4:10					
	•	"Called to resident room					
	=	nt on floor with left arm ned between side rail and					
	•	sting on rail. Resident					
	-	no pulse or heart rate					
	•	s nurse arrived in resident					
		low position, tabs alarm					
		not sounding, 1/2 side					
	*	nobility and positioning.					
	EMS unable to re						
		• • • • • • • • • • • • • • • • • • • •					
	A Care Plan, init	ially dated 3/8/11 and					
	-	Goal and Target Date" of					
	10/20/11, indicat	ed: "Problem Onset::					
	03/08/2011 I am	at risk for falls." The					
	"Approaches" in	cluded: "Keep call light					
	within reach." Th	ne Approaches did not					
	include a low bed	d nor a bed alarm.					
		are Plan, initially dated					
	_	ed with a goal date of					
		ted a problem of "I need					
	help completing	-					
		ded: "Provide one half					
		t me with my bed					
	mobility."						
	Physician orders	for the side rails, low					
	-	ms for safety were					
	lacking in the cli	-					
	During interview	with the Director of					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/19/2011 FORM APPROVED OMB NO. 0938-0391

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155348	(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION 00		E SURVEY PLETED /2011
	PROVIDER OR SUPPLIER		2819 N	ADDRESS, CITY, STATE, ZIP CO ORTH ST JOSEPH AVE VILLE, IN47720		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	Nursing [DON] she indicated Re bed in the low poplace on 9/23/11 alarm did not sortype alarm, and it the resident. The where the alarm how long the alarm indicated Reside to assist him in to During interview 1 on 9/27/11 at 1 after every fall, the adjusted. Unit M Resident A had a low bed since I the facility, and store intervention plan. The Unit M not know when the alarm was added During interview 9/27/11 at 10:45 was the nurse word 1 she had walked approximately 3 resting comfortal CNA # 1 had state approximately 4 Resident A lying	on 9/27/11 at 9:45 A.M., sident A had been in a position with an alarm in a position with a connected to a position box was connected or a position with a utilized his side rails arning side to side. The DON indicated or a position with a utilized his side rails arning side to side. The With the Unit Manager # 0:30 A.M., she indicated he care plan should be an ager # 1 indicated in air mattress and was in the had been admitted to she did not know why in were not on the care lanager indicated she did he intervention of an				

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S COMPL		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155348	A. BUI	LDING	00	09/27/2	
		133340	B. WIN			09/21/2	011
NAME OF F	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE		
PARKVIF	EW CARE CENTER				ORTH ST JOSEPH AVENUE VILLE, IN47720		
				<u> </u>	VICEE, IIVI7720		(2/5)
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	the side rail and t	the mattress. LPN # 1					
		and face were not					
		at the chin was more					
		inner part of the side					
	_	icated the resident was in					
	a low bed and ha	d an alarm on, but that it					
		PN # 1 indicated the					
	alarm box was at	the head of the bed.					
	During interview	with CNA # 1 on					
	9/27/11 at 10:55	A.M., she indicated she					
	was the CNA wh	o found Resident A. She					
	indicated she last	t saw the resident at					
	approximately 2:	25 A.M., and she					
		on his right side. CNA#					
	1 indicated when	she went in the					
	resident's room a	t approximately 4:10					
	A.M., she found	the resident with most of					
	his body on the f	loor, and his left arm on					
	the bed against the	ne rail. She indicated the					
	resident's chin wa	as resting against the bed					
	rail. She indicate	d the resident had an					
	alarm on, but tha	t it did not sound.					
		at 8:25 A.M., during the					
	initial tour, Unit	Manager # 2 indicated					
	Resident E was u	ıp ad lib, and did not					
	utilize his side ra	ils. Resident E was					
		time lying in bed, with					
	half side-rails up	on both sides of the bed.					
	Unit Manager # 2	2 indicated that the					
	resident was aler	t and oriented, and if he					
	wanted to pull th	em up, he could.					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/19/2011 FORM APPROVED OMB NO. 0938-0391

l	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155348	(X2) MULTIPLE CO A. BUILDING B. WING	00	COM	TE SURVEY IPLETED 7/2011
	PROVIDER OR SUPPLIER		2819 N	ADDRESS, CITY, STATE, ZIP C ORTH ST JOSEPH AVE VILLE, IN47720		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	reviewed on 9/27	led, but were not limited				
	2/2/11 and on the	der, initially dated on e current September 2011 , "Half upper side rails I mobility."				
	dated 12/22/10 a indicated, "Why being considered For [increased] b mobilityReconrail Left upper lo	For Use of Side Rails," and updated 8/29/11, is the use of a side rail(s) is Resident requested - sed amended Type: 1/2 partial ower Right upper lower, Use [left blank]8/29/11 ight to aid turning side to				
	reviewed on 9/27	A assignment sheet, 7/11 at 11:00 A.M., did use of the side rails.				
	initial tour, LPN utilized bed rails observed at that	8:40 A.M., during the # 2 indicated Resident B Resident B was time lying in a low bed, ls up on both sides of the				
		rd of Resident B was 7/11 at 12:05 P.M.				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155348		(X2) M	ULTIPLE CO	INSTRUCTION	(X3) DATE S		
			A. BUI	LDING	00	09/27/2	
		100040	B. WIN			09/21/2	011
NAME OF I	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE ORTH ST JOSEPH AVENUE		
PARKVIE	W CARE CENTER			1	VILLE, IN47720		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID			(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	~	led, but were not limited					
	to, Dementia and	Alzheimer's Disease.					
	A Dhygiaianla and	ler, initially dated 1/7/11					
	1 *	at September 2011 orders,					
		bed placement," and					
		s to assist with bed					
	mobility."	s to ussist with ood					
	A Side Rail Asse	ssment, initially dated					
	6/30/10, indicate	d, "Why is the use of a					
	side rail(s) being	considered? Resident					
	requested: to assi	ist with bed					
	mobilityRecon	nmendations Side rails(s)					
	are recommended	d at this time due to:					
	1 ^	Recommended Type:					
		eft upper Right upper.					
		Jse, Side rail(s) are					
		all times when resident					
		assessment was updated					
		1, 3/26/11, 4/19/11,					
	· ·	5/11. The most recent					
	·	/16/11, indicated, "No					
	changes, com PC	OC [plan of care]."					
	A "Nursing Asses	ssment of Fall," dated					
		.M., indicated, "Exact					
		e by bed in resident's					
	roomPossible (Causative [sic] factors					
	identified: Confu	sion"					
		a . D 52.03					
		a Set [MDS] assessment,					
	· ·	icated the resident scored					
	a 4 out of 15 for	cognition, with 15					

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155348	(X2) MU A. BUILI B. WING	DING	NSTRUCTION 00	(X3) DATE S COMPL 09/27/2	ETED
NAME OF PROVIDER OR SUPPLIER PARKVIEW CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2819 NORTH ST JOSEPH AVENUE EVANSVILLE, IN47720				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	F	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	(X5) COMPLETION DATE
		ntal impairment, and re assistance of two + oility.					
	updated with a ta indicated a probl risk for skin brea incontinence." To	ially dated 7/10/10 and arget date of 12/15/11, em of "[Resident B] is at kdown due to he approaches included: f siderails to assist with					
	9/27/11 at 3:30 P residents were in	with the DON on O.M., she indicated that low beds due to fall e side rails were to assist in bed mobility.					
	sheet, on 9/27/11	f the CNA assignment at 11:00 A.M., f the use of side rails was					
	initial tour, LPN utilized side rails observed at that t	8:40 A.M., during the # 2 indicated Resident C a. Resident C was time lying in a low bed ls up on both sides of the					
	reviewed on 9/27	rd of Resident C was 7/11 at 2:45 P.M. led, but were not limited					

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		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155348	A. BUII	LDING	NSTRUCTION 00	(X3) DATE S COMPL 09/27/20	ETED
NAME OF PROVIDER OR SUPPLIER PARKVIEW CARE CENTER				2819 N	ADDRESS, CITY, STATE, ZIP CODE ORTH ST JOSEPH AVENUE VILLE, IN47720	00/21/2	
					VILLE, 11147720		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	3/7/08 and last up indicated: "Why being considered mobility. Medica Cognitive: Impair walkingSide rathis time due to: requestRecommended resident is in bed notation, dated 2/2 changes, continued A Physician's ordered and on the current indicated, "Half Simobility." A Care Plan, date problem of: "I had Approaches indicated when in bed to as Does not prevent A MDS assessment indicated the resifur cognition, with mental impairment."	is the use of a side rail(s)? Resident requested for: Il Symptoms Pain, red safety when il(s) are recommended at Resident mended Type, 1/2 partial Right Upper. Side rail(s) d at all times when" The most recent /28/11, indicated, "No e POC." Ider, initially dated 5/13/11 at September 2011 orders, Side Rails for bed ed 5/13/11, indicated a eve a history of falls." The cated: "Half siderails up ssist with bed mobility. Trising." ent, dated 8/20/11, dent scored a 1 out of 15 ith 15 indicating no ont, and required ince of two+ staff for bed					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155348		i i	BER.		INSTRUCTION 00	(X3) DATE S	
		A. BUILDING B. WING 09/27/2011					
NAME OF F	PROVIDER OR SUPPLIER		D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
				1	ORTH ST JOSEPH AVENUE		
	EW CARE CENTER		-		VILLE, IN47720		915)
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		ATE.	DATE
		f the CNA assignment					
	sheets, on 9/27/1						
	documentation w C utilized side ra	vas lacking that Resident					
	C utilized side la	.118.					
	6. On 9/27/11 at	8:40 A.M., during the					
		# 2 indicated Resident D					
	· •	sired and did not utilize					
		nils were observed on					
	down on the othe	ped; up on one side and					
	down on the other	er side.					
	The clinical reco	rd of Resident D was					
	reviewed on 9/27	7/11 at 2:30 P.M.					
	"	led, but were not limited					
	· ·	lity and Alzheimer's					
	Disease.						
	A MDS assessme	ent, dated 7/20/11,					
		dent scored a 3 out of 15					
	· ·	vith 15 indicating no					
	1 ^	nt, and required limited					
		person for bed mobility					
	and transfer.						
	A Care Plan, date	ed 8/5/10 and updated to					
	l '	0/23/11, indicated a					
	_	ds assistance to complete					
	-	and grooming tasks."					
		included: "1/2 siderails					
	for bed mobility.						
	A Side Rail Asse	ssment, initially undated					
		updated 7/23/11,					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M A. BUII		onstruction 00	(X3) DATE S COMPLE	ETED	
		155348	B. WIN			09/27/20)11
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
PARKVIEW CARE CENTER				I	ORTH ST JOSEPH AVENUE VILLE, IN47720		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
	``			TAG CROSS-REFERENCED TO THE APPRODEFICIENCY)		TE	
(X4) ID PREFIX TAG	indicated, "Why being considered Bed MobilityR partial rail Left U Recommended U Uses 1/2 SR to as mobility." A Physician's ordindicated, "1/2 si mobility." During review of sheets on 9/27/11 documentation or lacking. 7. The current fact Rails, dated 11-8 DON on 9/27/11 included: "1. A S be completed upor readmission, and physician's order Restraint Informarequired for the unitarial required for the unitarial required for the unitarial results."	is the use of a side rail(s)? Resident requested For ecommended Type, 1/2 Upper, Right Upper, Use [left blank]7/23/11 ssist [with] bed ler, dated 9/23/11, derails up to aid in bed If the CNA assignment at 11:00 A.M., f the use of siderails was ecility policy on Side 5, was provided by the at 9:45 A.M. The policy ide Rail Assessment will on admission,		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	(X5) COMPLETION DATE
		bed rails. 4. When a					
		s arises, instruct residents se and correct use. 5.					
		are indicated, bed must be					
		t position, except when					
	care is being prov	vided"					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

l		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155348	(X2) MULTIPLE CC A. BUILDING B. WING	00	COMPLETED 09/27/2011			
NAME OF PROVIDER OR SUPPLIER PARKVIEW CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2819 NORTH ST JOSEPH AVENUE EVANSVILLE, IN47720					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	E COMPLETION			
		relates to Complaint						
	3.1-45(a)(1)							